PRESCRIPTION FOR PRIVATE PRACTICE*

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My prescription for the private practice of child psychiatry is a hearty dose of competence, patience, flexibility, creativity, humor, wonder, and faith—faith in the mutability of individuals and families and faith in the developmental process. The patient himself is a compound phenomenon with many ingredients: the child, parents, siblings, peers, grandparents, teachers, tutors, pediatricians, orthodontists, music teachers, coaches, housekeepers, babysitters, dogs, cats, hamsters, and snakes. At one time or other any or all may knock on the consulting room door and ask to be heard. It is not infrequent for a youngster, especially a teenager, to arrive with a classmate, even several—a resistance, admittedly, but sometimes also a gesture of getting help for a friend or including the therapist in an important peer experience.

The following is a discussion of some of the major areas involved in setting up a private practice: the office, the referral, the evaluation, the treatment, the termination.

The office. The need for flexibility quickly becomes apparent in arranging the physical aspects of one's office. Lately, many psychiatrists find it difficult to get adequate office space at an affordable price. Ideally, one would have a large bright office with a separate playroom designed for working with small children, child groups and families. Most people manage with a good deal less. An accessible toilet and a good sized waiting room are desirable to accommodate whoever will be escorting younger children to their sessions. Childproofing and soundproofing are important considerations as is a good working relationship with officemates, especially if they do not work with children. Sturdy, colorful, washable decor and furnishings are "in"—precious antiques, silks and objects d'art are "out." Things should

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be attractive but replaceable. Do not be too highly invested in anything in the office or waiting room. I have found that if one sets a tone by keeping things reasonably clean and tidy, patients and families follow suit. It helps to have friendly doormen and neighbors, but that is more than a little beyond one's control. Office location may be difficult to control as well, but look for an area where many children live or go to school. Ideal locations are near good public and private schools, in residential areas, and near public transportation. It works best if older children can get to the office comfortably and safely on their own, and parents and sitters appreciate convenience as well. Nearby garages and stores in which parents and siblings can shop or stroll while waiting are advantageous. Proximity to a park or playground and a good coffee shop is helpful, especially if one is inclined to work with children outdoors or to provide food treats on such special occasions as birthdays or holidays. A visit to a nearby art gallery played a significant role in the treatment of one youngster I worked with, and an occasional restaurant visit was important in furthering the socialization of another.

Inside the consulting room, a closet, shelves or toybox can store necessary treatment materials. It is ideal if one can provide individual storage space for each patient, but at least one can make available a file folder or slim box to hold drawings, small toys, or nonperishable left over snacks. On the subject of toys, select them for brightness, sturdiness, and replaceability and limit them to a few for each age group. Toy supplies can be expanded to meet the particular treatment needs of a particular youngster: "Star Wars" figures for a young astronaut, popsicle sticks for an older puppeteer. Handicapped youngsters may require special toys or modifications in the treatment setting. One must know one's own limitations; over time they will become apparent. Be careful about introducing active toys. I quickly switched from a wiffle ball to a nerf ball; some people should avoid both. Magic markers are safer to start with than oil paints. Also, one has to decide whether or not to provide snacks. If one does not, it is difficult to say no to youngsters who bring their own. They are usually famished after school and the custom with tutors, music teachers, and sports groups is to supply snacks or at least permit them. If one is nervous about the carpet, a tray and a few napkins will usually alleviate the anxiety. I always have sheets of blank paper available which children use to draw self-portraits, family portraits, and layouts of their apartments, to illustrate dreams and stories, to write me notes on unmentionable topics, and to make paper airplanes. I also have a few diagnostic tools available: a Peabody Picture Vocabulary Test, Bender cards,

and a few objects to test for soft neurological signs. I leave more extensive testing for the psychologist.

The referral. In my experience, the best referrals usually come from colleagues, so keeping up professional friendships and affiliations is vital to maintaining an active practice. Most colleagues are not put off when solicited for patients; they do it in their turn, so don't be shy. It is stimulating, public spirited, and self-interested to consult with pediatricians, schools, and community groups and to serve on child-advocacy committees. In the process, one educates about the usefulness and limitations of consultations and treatment and encourages referrals. Once referrals have been made, give periodic feed-back to referral sources; they usually want to know how things are progressing. They will consider referring in the future, especially if the progress or outcome is good. Do not panic; accept invitations to speak at the Academy of Medicine or to advise television and radio producers on aspects of your expertise. You may not get referrals directly, but at the very least you have sharpened your consultation and communication skills. Publishing, especially in more popular journals, may generate referrals but I have found that impersonal referrals such as those coming from directory listings tend to be less workable. Most people do not know what they are looking for, what they need, or what a child psychiatrist can offer. A personal or professional referral source usually screens for the appropriateness of the referral, and, more important, sets a positive tone in preparing the family for the evaluation process. Cultivating a subspecialty such as hypnosis, psychopharmacology, substance abuse, eating disorders, or psychoanalysis may generate selected referrals, particularly if one has a reputation in that field. Often, a reputation is developed when people hear that one has handled a number of similarly difficult situations well. Keep in mind that most child psychiatrists make a gradual transition from training to full-time practice by holding part-time jobs in hospitals, clinics, schools, child care agencies or the courts. In fact, very few child psychiatrists have full-time practices in child and adolescent psychiatry; most see a good number of adult patients and retain a part-time position, if only for a few hours a week. The latter is often done for diversification, interest, and the opportunity for professional contacts. A voluntary faculty appointment at a nearby medical school, where one can supervise residents and fellows or be involved in teaching and research, is the route that others, like myself, take for the same purposes.

The evaluation. Now that one has one's office and a referral, what happens next? The phone rings and one makes arrangements for the evaluation. It is helpful to get a brief statement of the main problem and the names, ad-

dresses, phone numbers and ages of the principal parties: at this point, usually the identified patient, the parents and the siblings. I record the identifying data on a card which will constitute the patient's record. This card will eventually contain the diagnosis, the names and phone numbers of involved professionals, the fee, the dates of visits, the monthly charges and payments, and the disposition, if referral is made to someone else for treatment. Be prepared to be asked about fees and prognosis at this time and encourage parents to wait to discuss these issues during the consultation.

For the first visit, it is best to see both parents, even estranged ones, if they can agree to this. This practice is helpful in conveying to both child and parents that both the parents are important in the life and treatment of the child. It is also necessary to establish who will be emotionally, legally and financially responsible for the evaluation. Also, one must be clear about custody issues; otherwise, one may find oneself in a very uncomfortable and untenable position at some later date. Give parents, or adolescents who may insist on being the first to be seen, clear directions how to get to the office building and how to negotiate the building and the suite. Prepare them for whether the doorbell is to be rung, if the door is locked or open, where to find the coatracks and the bathrooms. Most physicians have a receptionist to do this; most psychiatrists do not. It makes people feel much more welcome and much less helpless and frightened if some of these concrete issues are spelled out, since the more urgent, emotional ones cannot be as yet.

I often arrange a first meeting at a time when I can see parents for several sessions in a row, and I bill for the amount of time actually used. In this session, in addition to taking a comprehensive history, I help parents to formulate how to inform their child about the evaluation. A child who is secure that his parents are comfortable with the consultant and the evaluation process is infinitely more accessible than one who has gotten the message that his parents are sending him to someone because they are angry with him or terrified about his condition or the possible need for treatment. This session is also one in which one needs to establish the parameters of the evaluation process: how many sessions will be involved, and one's fee, payment and cancellation policies. In the course of the consultation it can be helpful to encourage parents to call or drop a note if important things occur to them that they neglected to tell you in the anxiety of their visit. Insist that a parent accompany the child to the first visit and to others as needed.

With teenagers, it is helpful if parents offer but do not demand to come along. Caution parents not to be disappointed if they are turned down, since this is the usual case. Their offer, however, is usually appreciated, and sets

a positive tone for the evaluation process. One must review with youngsters, even very young ones, why they are coming and what the evaluation process is all about. They need to know what one's policy is about confidentiality and that one will be discussing one's findings and recommendations with their parents at the end of the evaluation.

There are pros and cons to doing an evaluation if one does not have treatment time available. Sometimes it is easier for parents to accept the recommendation of a consultant who will not be administering the treatment; they may feel that the recommendation is more objective and less self-interested. However, if one will not be the treating physician, make that clear to both parents and child in order to limit, at least consciously, the degree to which they become invested in the relationship. One may find that one needs to involve other professionals in the evaluation, and it may be advisable to arrange for such consultations before one completes one's evaluation. It is necessary to have access to a number of reliable specialists to perform adjunctive evaluations such as psychological testing, speech, hearing, ophthalmologic, and neurological examinations. I have preprinted release-of-information forms available to obtain parental permission for requesting records from hospitals and other professionals and for communicating verbally or in writing with necessary agencies or individuals.

When I am ready to meet with parents to discuss my recommendations, I sometimes set aside a double session. Occasionally, a follow-up session needs to be scheduled so that parents can integrate my observations and treatment recommendations. In this session, I review the presenting complaints and symptoms and the reports of other professionals. I relate my observations and explain their significance. I try to list the child's strengths as well as weaknesses and indicate how the former can be used to promote improvements in the latter. I indicate what further evaluation, follow-up or treatment may be necessary. If I am recommending treatment, I help parents formulate how to tell their child that he will be coming back to see me or going to see someone else for regular therapy sessions. How sensitively parents do this can have a profound effect on the child's ability and eagerness to participate in the treatment process. Parental reluctance is usually reflected in whining, silent or uncooperative children. If I intend to be the treating psychiatrist, I discuss the treatment situation: fee, payment, cancellation, and vacation policies, appointment times, amount and type of continuing parent contact. Some psychiatrists put their policies in writing and give a copy to parents at the end of the evaluation. However one does it, it is best to deal with these difficult issues at the outset so as to avoid unpleasant com-

plications later on. Consistency is important in these areas. For instance, I try to bill at the same time each month, and I request that filled-out insurance forms be given to me in advance of the billing time since it is more efficient to fill in my portion at the time of preparing the bill. I note on the record card the date the insurance form is filed and keep copies of forms that contain descriptions of symptoms or treatment goals and progress. Policies one establishes at the beginning of one's career are bound to change with time and experience; what works for one person and family may not be right in another set of circumstances.

The treatment. One is now ready to begin the treatment. A schedule must be set for the child and the parents. I encourage parents to consult with youngsters of grade school age or older children about the best days and times for them to have their sessions. If a session interferes with a favorite activity, a child's cooperation is much less assured. Parents need to be seen regularly to gather information about the child and the family, especially when one is treating small children who are not accurate reporters. Seeing parents is also crucial in maintaining the treatment alliance. The frequency of parental contact is determined by the needs of the family and the treatment. Not infrequently, one comes to see that one or both parents require treatment as well. Clearly, one must be tactful in making such a recommendation and have colleagues to refer to who will be sensitive to some of the issues of child treatment and parenthood as well as be able to work with the parent on more personal difficulties. At times phone contact or a scheduled session with a baby-sitter, teacher, tutor, or any of the others involved in the child's life may be useful if agreed to by the parents.

One must determine how much availability you will have outside of scheduled appointments. Some child psychiatrists set aside a time each day or several times a week when parents can call to ask questions or report family events that may go unreported by the child. One advantage of an answering machine is that parents can easily communicate their observations and concerns in a timely fashion. Nighttime and weekend availability must be considered. Office calls can be forwarded to a home number and be picked up there in person or by an answering machine. In emergencies, personal availability or a beeper system may be necessary. However, one must think carefully about giving one's home number to patients. It is easier if one has a separate line for professional calls. Again, one must know one's limitations; not everyone can comfortably interrupt preparation of a tricky recipe, viewing the Super Bowl, or dealing with his own family crisis to speak with a concerned parent. With older youngsters and adolescents, I provide

a professional card and let them know that they are welcome to call and leave a message if they ever feel they need to. Occasionally they will call to change a session time or to complain about their parents or siblings. Even if I do not get back to them right away, having an immediate verbal outlet for expressing their distress can provide some relief; this can be true for parents as well. I also use the cards to inform parents of changes of session time or my vacations, though I confirm by phone that they have received the information.

Sometimes circumstances dictate out-of-office visits. If a youngster is hospitalized a visit might be indicated. I do not charge for friendly visits, but if my presence is requested by the child, medical staff or parents and is agreed to by the parents as part of the hospital treatment, I submit a regular bill. Extended hospitalization or home illness may necessitate continuing the therapeutic work by phone. This method can also be used to deal with camp emergencies and with the occasional youngster who goes to a boarding school where no therapy is available or with whom a change of therapist is ill-advised. Since there are usually many vacation days at prep schools, there are usually ample opportunites for personal contacts several times a year. In a treatment in which the child requires medication, I usually inform both the parents and the child about the effects and side effects the child may experience and how to deal with them. I keep my medication records on a duplicate of the record card and encourage parents to keep a similar record on which they note improvements, exacerbations, and side effects. I inform or have the parents inform the pediatrician and appropriate medical specialists, teachers and tutors about the medication regimen.

During the course of an extended treatment, situations may arise that lead to a temporary or permanent change in the treatment method or agreement. One may decide to see a child together with one or both parents, to add or substitute family or group treatment, to increase or decrease the frequency of sessions. Whatever the modification, it must be discussed so that all concerned are reasonably comfortable with the new arrangements. As children get older and healthier, they need to be encouraged to take greater responsibility for their treatment, both the content and the practicalities. They may also make more frequent and more reasonable requests for time changes so that they can participate in important peer and school activities. Flexibility is necessary, but also awareness of resistance; a balance must be struck between maintaining the structure and focus of the treatment and permitting the exercise of growing autonomy and peer-group identification.

The termination. I have found that it is useful at the beginning and end

of each school and treatment year to review with the parents and the youngster why he is in treatment, what gains have been made and what conflicts and symptoms remain to be addressed. When the subject of termination arises, I go through a similar review and indicate that the decision to finish treatment should be a joint one. If the termination seems indicated, we set a date which permits a reasonable length of time for the working through of issues that come up in response to the ending of treatment. It is also well to indicate that the date may have to be reconsidered if the work during this phase suggests that more time is needed to complete the therapeutic process. I indicate that I will be available for consultation or for further therapeutic work if that should prove necessary during the years to come.

Unplanned terminations necessitated by financial difficulties, relocation of the family, transfer to out-of-town school or college, or parental dissatisfaction with the treatment are best discussed nonprecipitously and in person with the parents and child so that some closure on the therapeutic relationship is effected. In the case of parental dissatisfaction, this task must be handled carefully so as not to polarize the child against the parents to whom he owes his primary allegiance and on whom he must continue to depend for support. What I do is review the original indications for treatment, what has been accomplished, and, if appropriate, what remains to be addressed in future treatment. I also indicate my availability to speak with future therapists, schools, tutors, etc. should the parents feel that would be helpful.

Some psychiatrists, in the interest of informing themselves about the long-term outcome of their therapeutic efforts, arrange to maintain periodic contact with parents or patients after termination. If this practice is introduced at the beginning of therapy or early in the termination process, it need not place too great a burden on the closure of termination. Parents and youngsters may welcome such an arrangement as indication of professional diligence and interest, and assurance that if problems arise after the termination help will be available to them.

In conclusion, I have discussed five important areas in the private practice of child and adolescent psychiatry. If one learns to deal successfully with the complex demands of treating children and adolescents in this setting, one is usually rewarded with the pleasure of seeing initially sad, anxious and angry youngsters mature into lively, involved, self-fulfilled, joyful people. The ending of one's fellowship or residency is only the commencement of many challenging, wonder-filled years of learning, self-exploration and healing. I hope all of you enjoy them thoroughly.